

even gold or silver. Currently, there are very few data in the literature about STIs and genital piercing but it has been postulated that there can be an increase in the risk of transmission of blood borne viruses as well as other STIs because of damage to condoms caused by these objects. A recent study¹ also did not find any association between body piercing and genital infections in general; however, we wondered whether genital piercing should be included in the KC 60 data collection. We would welcome observations from the readers of *STI* on this subject.

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1 Willmott FE. Body piercing: lifestyle indicator or fashion accessory? *Int J STD AIDS* 2001;12:358-60.

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Safer sex in HIV infected patients in London: practices and risks

EDITOR.—Recent figures from the Public Health Laboratory Service (PHLS) report¹ have shown the largest number ever of new cases of HIV infection (2868 cases) during 2000 in the United Kingdom. The majority of HIV infected individuals attending clinics for their treatment and care will have been counselled and strongly advised to practise safer sex. Specific risks of unsafe sex will be summarised, including the risk of transmission of HIV to their partners, as well as their own risk of acquiring new sexually transmitted infections, and the spectre of multidrug resistant HIV variants.

The overall effect of such safer sex messages were called into question by Dodds *et al*² who recently reported evidence of an increasing incidence of high risk sexual behaviour among homosexual men in London. The accompanying editorial by Grulich³ called for improved data on risk behaviours, specifically in HIV infected individuals. We can present data on this from a questionnaire survey of patients attending the largest HIV outpatient centre in London.

The questionnaire was distributed to 500 consecutive individuals attending the Kobler HIV outpatient clinic at the Chelsea and Westminster Hospital during spring 2000. The confidential questionnaire could be completed anonymously if the patient wished. Data were gathered concerning the individuals' sexual behaviour over the past year in terms of number of sexual partners and episodes of unprotected sex. Further data were collected on whether individuals had sexually transmitted infections (STIs) diagnosed in the past year and/or attended for sexual health screening (table 1). We also asked them how they had acquired HIV infection.

A total of 494 legible questionnaires were suitable for analysis. Anonymous questionnaires were received from 240 respondents, whereas 254 (50.8%) disclosed their identity, and 35 (7%) were female. Although 317 patients (64%) reported engaging in only protected sex in the previous 12 months, 173 (35%) individuals had unprotected penetrative sex in the past year. This figure for HIV infected individuals has a remarkable concordance with the data for unprotected

intercourse in a sample of homosexual men which reported a prevalence of 38%.² On further analysis of this group, it was revealed that a substantially higher proportion, 93 (54%), had unprotected sex with more than five partners, of which 40% had more than 10 sexual partners in the past 12 months.

Only 252 patients had a sexual health check up in the past year. There was a significant association between having a check up and reporting having unprotected sex. However, of those who had unprotected penetrative sex in the past year, 67 (39%) did not have a sexual health screen. A sexually transmitted infection had been diagnosed in 41% of respondents in the past year, which was significantly⁴ associated with their increasing numbers of sexual partners.

We believe that major efforts to encourage sexual health check ups must be targeted to the key population of HIV infected individuals. The majority (76.2%) of our patients who had a sexual health check up in the last year, did so at the GU medicine clinic in the same building, contrary to the popular belief that HIV patients do not use local services for sexual health check ups.

Oral sex causing HIV transmission is biologically plausible though it is considered a less risky activity compared with unprotected vaginal and anal intercourse⁵. However, the frequency of its occurrence may serve to increase its relative contribution to overall HIV transmission. Inflammation or ulceration of the oral mucosa due to mouth ulcers, gingivitis, periodontal disease, pharyngitis, bleeding gums after tooth brushing or flossing could potentially lead to the increased risk of HIV transmission.

Six per cent of our studied population believed they acquired HIV infection through unprotected oral intercourse only. On reviewing the notes of the identifiable patients we concluded that five out of these 15 patients had no other risk factor other than unprotected oral sex recorded at any time during their counselling or management records, which can account for their HIV transmission. The remaining 10 patients' notes did not have enough evidence to support their claim that they acquired HIV disease through oral sex only. Three out of five of these patients had never engaged in anal sex and the remaining two always used protection.

Following this observation we have further identified six patients who have probably acquired HIV through unprotected oral sex, and we can summarise data from all 11 patients. They were all homosexual men. Eight out of 11 never practised anal sex and the remaining three always used protection. Five of them were living with long term HIV positive partners and were fully aware of

safer sex issues. However, all of the five considered unprotected oral sex as a safer activity. Six out of 11 were reported to have recurrent infections of the mouth; two had pharyngeal gonorrhoea, one had herpes simplex stomatitis, two had idiopathic ulcerative stomatitis, and the remaining one had his tongue pierced 10 weeks before his seroconversion. Although oral sex is a lower risk activity for HIV transmission, in compromising situations where the mucosal barrier of the mouth is not intact, it can play a larger part in HIV transmission and can possibly be the sole cause of transmission.

Despite the recent EAGA report,⁶ while such uncertainties about the contribution of oral sex to new HIV transmission exist, the delivery of clear safer sex messages to this and other groups will remain difficult to implement.

Our department is now developing a fast track service to enable HIV infected individuals to more easily combine sexual health screening with their HIV outpatient appointment. Efforts by both statutory services and advocacy and support organisations for HIV infected people need to be coordinated to promote these initiatives.

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- 1 CDSC. AIDS and HIV infection in the United Kingdom: monthly report. *Commun Dis Rep CDR Wkly* 15 February, 2001
- 2 Dodds JP, Nardone A, Mercey DE, *et al*. Increase in high-risk sexual behaviour among homosexual men, London 1996-8: cross sectional, questionnaire study. *BMJ* 2000;320:1510-1.
- 3 Grulich A. HIV risk behaviour in gay men: on the rise? *BMJ* 2000;320:1487-8.
- 4 Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. *Lancet* 1998;351 (suppl III):5-7.
- 5 Dillon B, Hecht M, Swanson M, *et al*. Primary HIV infection associated with oral transmission (The options project UCSF). Poster presentation San Francisco January 2000, Seventh conference on retroviruses and opportunistic infection.
- 6 Department of Health. *Review of the evidence on risk of HIV transmission associated with Oral Sex*. June 2000. Report of a Working Group of the UK Chief Medical Officers' Expert Advisory Group on AIDS. London: DoH.

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BOOK REVIEWS

Sexually Transmitted Diseases, Vaccines, Prevention and Control. Ed Stanberry LR, Bernstein DI. Pp 457; \$119.95. New York: Academic Press, 2000. ISBN 0-12-663330-4.

It has become increasingly clear that STIs cannot be controlled simply by diagnosis and treatment of the relevant pathogens alone. This new volume on STI prevention is especially relevant as we struggle to provide access for those already infected with sexually transmitted organisms. My first thought when I looked at this book was influenced by the cover illustration of a herpes simplex virion. It looked like another worthy tome

Table 1 Reported incidence of sexually transmitted infections (STI) over past year by respondents

STI	Diagnosed with an STI in the past 12 months (n = 102)
Gonorrhoea	36 (35.3)
Chlamydia/NSU	22 (21.6)
Syphilis	4 (3.9)
Herpes (first episode)	20 (19.6)
Warts (first episode)	29 (28.4)
Others	13 (12.7)
Combination of STIs	22 (21.6)
Gonorrhoea + chlamydia/NSU	8 (3.8)